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BOOKS — AND G.B.S.

So much has been written in this JOURNAL and others on the subject of medical text-books that it is difficult to believe that the last word has not been said. The only excuse for disinterring the subject is to offer constructive suggestions, with suitable apologies for our presumptuousness in rushing in where other editors have trodden in vain.

Almost all critics agree that there is a dearth of medium-sized books—intermediate between the synopsis written in medical journales and those monumental tomes, the standard works of reference. As to what should go into these medium-sized books there is no great measure of agreement. Probably no two persons make use of text-books in the same way and it is correspondingly difficult to make any categorical statement as to their function. There can be no question that it is impossible to get a satisfactory idea of a disease from reading about it. Books can only be used to reinforce clinical experience. The superficial study of a particular group of diseases in a text-book may give an impression that they are all much of a muchness as regards their symptoms and signs, and a more detailed reading may be equally misleading, giving the impression that they can be differentiated and diagnosed in the twinkling of an eye.

What a text-book should do, in addition to setting out the usual details about symptoms, signs, course, complications, etc., of a disease, is to give an account of its scientific background, its anatomical, physiological and pathological basis. Nowadays the unfortunate student is faced with an ever increasing multiplicity of specialised books, both large and small. Perhaps the essential interdependence of the various services that go to make up medicine could be stressed by a complete series of text-books

covering all the subjects studied for the first and second M.B.s and finals: the whole series to be edited and co-ordinated by one man, and preferably written by the staff of one medical school: each volume giving, where necessary, reference to others in the series. This plan will not commend itself to everyone; some will see in it one further step towards standardisation ("the curse of the age"), nevertheless it deserves sympathetic consideration. And finally, what medical school is better equipped to provide such a series than our own?

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Many people will have read and been irritated by Bernard Shaw's "review" of Dr. Douglas Guthrie's history of medicine. A consulting surgeon to the hospital sent a copy of the article to the JOURNAL office with "This needs answering" written across the top, and indeed it does need answering, but quite where to begin is another problem. The article is riddled with scientific inaccuracies; to deal with them in turn would need an extended article. He claims that most of what he knows about medicine has been taught him by doctors, whom he numbers among his best friends. They must be singularly unorthodox members of the profession. Who, for instance, told him that "Heart patients were, and still are, immobilised and stimulated with whisky until they die of hypertrophied liver"? The immobilisation of fractures, the use of potassium iodide in the treatment of syphilis, and vaccination are all dealt with in equally high-handed manner. He seems to deny the microbic theory of infection and to cite as evidence for that that antiseptic surgery has been replaced by the aseptic technique. And yet his main conclusion that poverty with its attendant squalor and dirt are responsi-

ble for much disease is surely valid? It is a pity that this important point, which cannot be sufficiently stressed, has been submerged under a welter of bogus scientific arguments. Also his claim that laymen should sit on the General Medical Council, to represent the patients, is reasonable.

Bernard Shaw is undoubtedly one of the greatest men of our time, and deserves our homage and our thanks on his eighty-ninth birthday, but he cannot be allowed to get away with so many preposterous statements unchallenged. He claims that he has not a down on doctors and yet he has always delighted in "having a go"

at them. Is it some quality of character of doctors that provokes him, the too unctuous bedside manner, the supercilious attitude to the layman and his opinions, the faintest trace of humbug? Or is it an impish cavilling at accepted institutions (such as once prompted him to take the chair for a lecturer who contended that the earth is flat). At any rate, he does the profession but scant justice. If he knew more doctors he would find that, like the surgeon who treated him for osteomyelitis of the foot, they "happen to understand the exact relationship between science and good sense wonderfully well—for a surgeon."

VISUAL EDUCATION IN MEDICINE

By FLT/LT. MANDIWALL

Can anyone deny the value of photography in medicine? No. Then why is it that it has not been employed in this art as it should have been? There are two reasons. One, that in the past, the teachers were not aware of the capabilities of photography; second, that when it was employed in the service of medicine, the photographs were so poorly executed that either they did not convey the meaning the lecturer wanted to put over or that the teachers themselves were ashamed of showing their own or their friends' handiwork. These excuses no longer exist. To-day, the value of photography in all the arts and sciences is well recognised, and also photography has been perfected to such an extent that one just cannot accept or execute a bad picture.

Photography is not mere button pressing or flicking caps on and off a lens. It has been proved as a science, and is a science of paramount importance. Those who take it up seriously can be compared to torch-bearers, who bring light, wisdom, justice and peace among mankind.

The often quoted Chinese proverb, "A picture is worth ten thousand words," is getting out of fashion now, for a really good picture is worth "X" times more than what the proverb suggests, the value of "X" depending upon the quality of the picture and its ultimate use. Visual education should be of paramount importance, as the educationists tell us, that about ninety per cent. of what we learn passes through the eyes, and also that what we see is believed to be more authentic and impressive than what we hear. There are quite a few visual aids and one could say much about them, as for example,

whether cine is better than still, sound or silent, subjects suitable for the same, value of drawings, specimens, blackboard and chalk, etc. One certainly does not want to enter into details of these, as this would not be a short paper but rather a big text-book. Each has its peculiar and inherent qualities not possessed by the other media.

The biggest change in photography and equipment came about after the first world war—1914-1918. New apparatus and materials were produced at a rate which had never before been thought of. New branches of photography, aerial reconnaissance and air survey work called for a solution to an entirely new set of problems. Radiography developed to a considerable extent leading to the double coated X-ray films to replace the clumsy thickly coated plates that had to serve during the first world war. It will be evident that few if any of these improvements arose from the intervention or the request of scientific workers in photography who were beginning to appreciate the qualities and the value of the tools that photography offered to them.

One need not remind oneself the part photography played during the second world war in bringing knowledge to millions of people who had never dreamt of touching that particular part of occupation in which they were forced to work during the last four or five years. What has helped them? Visual education has played its part to the most. In the future, methods of teaching will help more rather than the amount as in the past. The days are thus dwindling when the professor used to come and lecture to the students by reading adverbium lines from

his favourite book. The lecturer nowadays usually dispenses with his notes and gives as it were a running commentary with the visual aids which impress the mind forcefully and permanently. If we just cast back our eyes to our books we must confess that illustrations and drawings conveyed to us much more than hundreds of words.

Medical knowledge can be imparted in three ways, by the lecturer, by books, and by visual aids. Photography will never entirely replace the lecturer or books but it will materially help both of them to an extent which has never been dreamt of in the past. Now visual aids can be classified as follows:—

1. ORIGINAL MATERIAL.
 - (a) human body,
 - (b) wet or dry specimens.
2. MODELS.
3. ILLUSTRATIONS — BLACK AND WHITE OR COLOURED.
 - (a) drawings,
 - (b) sketches,
 - (c) photographs.

All of these can be presented by means of slides, film strips, and motion pictures.

Why is it that in the past medical photography has not been used as it should have been? It may have been due to (1) lack of knowledge in medical photography; (2) lack of personnel; (3) lack of skill and appreciation in executing medical photographs. These days one need not excuse oneself from not using photography in medical science as all the above mentioned reasons are invalid. To make the medical profession believe the advantages of photography one must consistently turn out photographs of high quality and these cannot be produced without adequate training and proper equipment. Is medical photography as easy as one is made to believe? In my opinion it is not, as the variations in such work are so great that it will tax the resources of the finest and the most expert photographer.

What are the qualities of a medical photograph? (1) Simple straight forward record photography with perfect definition and well graded tonal values. The importance of a good well finished print with perfect detail and tones cannot be underestimated. One never knows when that print will be required again; perhaps for publication, after 10 or 20 years, when sufficient material has been collected. If that print was not of the first quality it will lose all its value. The photographer must bear in mind the possibility of publication, as under the very best conditions there is always some loss of detail in the processes of reproduction for print-

ing, and therefore he must make quite sure of his definition and emphasis, the tones of light and shade, so that the final result is not meaningless when a bit of detail is lost. The problem of the medical scientific photographer is the same as that of a writer, namely that a writer does not write what he can understand, but writes so that he cannot possibly be misunderstood; in other words he must make the record clean enough so that it can be understood not only by the research specialist but by other workers at a later date and after it has been reduced to a half-tone print. (2) Must include essential portions only. (3) Must tell its own story. (4) Must be well presented, that is, absence of scratches, stains, spots and well mounted and finished. (5) If in colour, must be true to original otherwise may mislead diagnosis, as for example in skin lesions.

A medical photograph cannot be produced by an amateur who has occasionally dabbled in photography. One would expect the following qualities of a medical photographer. (1) Photographer of the first order. That is he must have a good knowledge in the fundamentals of photography. (2) Ingenuity, that is—he must have the power of ready invention and also be prepared to undertake work no matter how complicated the set up, or the technique may be. (3) Love of labour—always smiling in difficulties and ever prepared to work hard. (4) Observant. Power to observe should be a great asset to him. The continued practice of this gift will improve his approach both to the patient and to photography. (5) Thorough. Every step taken must be a perfect step, full of confidence and exactness. No make-shift or slipshod work of any kind must be allowed.

In the past many doctors had to do photography of medical cases for three reasons:— (1) For teaching students and addressing the profession. (2) For their own convenience. (3) to eliminate expensive photographic assistance. I must say that as the practitioner got busier in his profession he could not devote sufficient time to this side line, with the result that he had no option but to turn to the ordinary photographer and in the end he got disappointed with the results and what was the reason? Because the man he employed had not sufficient training and experience behind him.

I should like to make a statement—a statement perhaps objectionable to many of my colleagues but nevertheless true—that the duties and responsibilities of medical men are enough to occupy their time. A doctor with time on his hands is almost a contradiction in terms! Such men should leave photography to one who

is specially trained. If they must do this sort of work they should take time and trouble to learn to do it properly. Good medical photography is not a mere button pressing proposition. A broad knowledge of photography plus the skill to apply this information to medical subject is most vital.

One word about financial matters, as photography involves expense. How should the financial question be satisfactorily solved? In my opinion, the medical man who orders photographic work for his own use must be made responsible for the cost of the material and for the extra hours of work put in by the photographer. The expense for the photographic records of hospital cases and laboratory specimens should be met by the hospital. For their photographs, lady almoners are quite within their rights to charge paying patients a little extra, an amount sufficient to maintain a fund which will allow for photographs in charity cases, post mortem specimens, and other relevant matters, with only a slight burden to the private patients, but with far reaching benefits to those so aided. The hospitals and medical schools should realise that photographic records help to improve the scientific spirit of the reputation of the institution and should be glad to provide funds necessary to keep the photographic equipment in perfect working condition, pay for the materials, and last but not least, offer

a salary which is attractive to an able photographer. The time has come when no general hospital or medical school will be regarded as complete without the help of an efficient photographic department. For many years the standard of medical photographs was very low. It has certainly improved, a lot, but there is still room for further progress. Medical photography requires broad photographic knowledge and experience and thorough training in all branches of commercial photography, plus a natural aptitude for medical work. It is a specialised branch of the photographic art requiring the highest type of skill. If medical photography is to go forward, it must attract men and women with the fundamental training necessary to carry on the work with a minimum of error. It should be the aim of every person engaged in medical photography to deliver the very best work that can be made. Anything but the very best is a reflection not only on the photographer, but also on the institution he represents. Perfect results in every case, without exception, should be the aim and final goal of a medical photographer. Don't let ignorance, indifference and lack of imagination enter into your work. To defend such work as "good enough" is only admitting ignorance and slovenly thinking. Slovenliness in this respect is no more a virtue than it is in any other form of human expression.

A GENERAL HOSPITAL IN NORMANDY

By H. B. STALLARD

"Now all the youth of England are on fire,
And silken dalliance in the wardrobe lies:"
King Henry V., Act 2, Prologue.

This is a brief account of the conditions under which a tented general hospital worked in Normandy in the summer and autumn of 1944. Such adventures, trials, successes and failures that we had were in no way peculiar to this unit. Indeed, I know that others had a rougher and more exciting time than was our lot.

Security demanded that we spent four days in a marshalling area, a military "purdah," before embarkation. This retreat lay concealed in a wood and was surrounded by barbed wire. The U.S. and the British Army were synergic in the conduct of the camp. We never again enjoyed the hygienic advantages of "pre-dip"

and "dip," for cleansing our eating and drinking utensils. There was a constant service of good food amiably tendered by loose-limbed giants who chewed gum and were democratic. This monastic life under canvas had its points. We talked deeply of things that mattered and grew to know each other as a team should do. Some of our troops wrote that Stalag would have no further terrors for them after this, but these were men of the cinema, dance, cigarette sucking calibre.

Our day came and we marched out in three companies. In the sheds at the port the embarkation I weighed myself and found the load of equipment, small arms and uniform to be

84 pounds. So it was well to have trained. After some hours of waiting we went on board and in the hull of the transport lay cheek by jowl with the Pioneer Corps. We were grateful for a snap inspection by their commander which recovered equipment losses that had occurred with Maskelyne mysteriousness. We had been at sea nearly three hours and had just changed course when a ship to starboard struck a mine and her stern caught fire. Part of our escort turned back to escort her.

None will ever forget the sight of Arromanche. We came through squalls of rain into sunshine and a clear sky to see the coast of Normandy. Mine sweepers were busy forward and destroyers bounded to port and starboard. The harbour, made in twelve days, is an historic tribute to our Navy, Merchant Navy, Marine engineers and the Army who worked it. A balloon barrage protected it from low level attack.

We went over the side of our transport into landing craft which were designated Nan, Queen, Sugar, Mike, Love and Charlie. There is always someone who is easily gullible. The descent into the bobbing landing craft was down a narrow iron ladder and in full kit, steel hat, respirator at the alert and all the other parts of the military Christmas tree this was no mean physical achievement, particularly for those of substance and middle-age. To one such was given in jest the advice, "lean well back" as he was about to descend the ladder. The weight of his pack projected him suddenly backwards and he would have gone to the bottom like a stone had not a saving hand seized a part of his webbing harness. We circumvented a mine and went ashore to march up hill through a village and an orchard $1\frac{1}{2}$ miles to the transit camp, a bare field on some high ground. Here we rested on the grass and prepared an evening meal from part of our 24 hour rations. This ration, among other things that the Army does well, was admirably planned and simple to prepare. One of our chronic grouchers stated that the minced meat made from a dried cube tasted like roast monkey, but whether this was so or not, it was good. It rained. Six to eight miles away the guns were firing and as darkness fell the sky became like a giant firework display, and the noise increased as the British Army slogged its way towards Caen and Caumont. At about 22.30 we were ordered to fall in and we were marched off down a leafy lane. So ponderous and clumsy was our movement in the dark that we received pungent invectives from the bivouacers whom we passed. From one com-

fortable nest of "old soldiers" came the remark, "Is this a . . . g Panzer division?"

After about four hours of interlacing movement with military traffic we had gone about six miles and at 02.00 hours were decanted into an open field. We were grateful for the moon in these strange surroundings. For the next two weeks our daily round was concerned with fending for ourselves in orchard and fields. There was nothing stereotyped or regimented about the style of our bivouacs, which expressed much individuality in construction. Some arranged elaborate arbours in the hedgerows, others constructed from sticks wooden cradles which kept them clear of the dewy ground. Our surgical specialist, E.N.T. specialist and myself formed a trefoil pattern with our heads based upon a young sapling from which we draped gas capes to protect our heads. Water was hard to find. A pump about half a mile away served a shallow well, but this was soon banned, for the farmer required this for his beasts. Articles of great value were a disused tin for holding water, pieces of wire and a strip of sacking. Upon such things depended our major comforts.

One water cart holding 350 gallons served us. This had to travel some miles to a river the pollution of which was evident. The integrity of those who collected the water was not of the highest grade, they were not gifted with a bacteriological conscience and failure to supervise sterilization caused the consumption of some infected specimens with the expected consequences. Sometimes there was no water for washing and none for drinking from 09.00 hours to 20.00 hours. Our feeding utensils were rinsed in one pail of water which served about 360 of us, including our engineers and pioneers. Later this single cart had to serve a hospital with 1,100 patients, the above-mentioned 360 and about 80 nursing sisters as well. A pipe line did not reach us till October, when we slipped about in a sea of mud, and eventually closed.

Sanitation was inevitably crude. At first a democratic affair for all ranks to accommodate 32 in a row, was fashioned by felling a slender tree supported by two props over a ditch. Privacy was secure in the vicinity of an unexploded mortar bomb in the hedge of an adjacent field. It was hot and the white dust of Normandy roads was irritating to the eyes and respiratory tract.

Our site for establishing a hospital was changed and at last one day we were stung into activity by an order to open a 300 bedded hospital in three days and to expand this to

1,100 in five days. With surprising suddenness tentage and equipment was tipped into our field and we toiled daily until light failed erecting tents, sore and blistered by friction from guide ropes and canvas. In all this sweat and labour there were moments of light relief. In preparation for the advent of the Sisters the pioneers had prepared a pit 12 feet deep by 2 feet by 20 feet. This gehenna they had left unguarded during their lunch time. I forgot to mention that the beasts of a farm, horses, cattle, pigs and hens wandered freely about our bivouacs. An enterprising sow of gross dimensions came in her reconnaissance for forage to the edge of this pit and in a moment of ataxy plunged into the depths and was thus trapped. We acquainted *Monsieur le fermière* with this catastrophe and the lively scene that followed was rich in incident. The alarm was raised as only it can be in Latin countries and running *en echelon* and exclaiming volubly there came all hands bearing ropes, a ladder and other equipment for the operation of extraction. *Madame, la fille de la maison*, and some inquisitive children came trotting in the rear of the assault party. Monsieur, arrived at the abyss, quickly surveyed the situation and decided on a plan. His pear-shaped figure was lowered in the rear of the sow and ropes were passed transversely beneath her liberal belly. These were flung up to the tugging team disposed on either side of the pit. The volume of chatter was considerable and it rose to a crescendo as the warrior in the arena dived beneath the sow to effect a vis a tergo, as she was levered up her cloven hooves beat upon the pate of her subterranean rescuer. A moment of thrilling suspense was afforded when the surface deliverers gave under the strain and Monsieur's knees ceased to be braced.

For adequate ablutions some of us walked or ran three miles to a little water-fall in a valley. Immediately above this a herd of swine wallowed in the mud at the verge of the stream and, soaped all over, we lay beneath the rich flora that this cascade poured upon our hot and soiled bodies. About October the swine closed their season of wallowing, human attendances fell to the smaller single numbers, but the R.A.S.C. were wont to tip their waste oils and other garbage into the water and I resorted to cold douching outside my tent, enshrouded in darkness, at 23.00 hours nightly. The sound of this made those abed beneath six to eight layers of blankets feel the warmer and I had the pleasure of steaming.

In the early days the Luftwaffe came over us at night and there was a clang of steel hats

followed by the pause of indecision as to the relative anatomical value of the mid-thorax, cranium and abdomen. Our ack-ack fire was the greater menace and when dawn came we found long slivers of ragged shell fragments near our resting places and even on a pillow. Old soldiers dug themselves in.

About the eve of opening the hospital there arrived in our orchard a screen of outriders in a variety of motorized vehicles and from an assortment of units, including the R.A.F. We became aware that these were the "boy-friends" of the Nursing Officers and were the heralds of their approach. About an hour later they arrived, a memorable invasion of our monastic precincts. Several lorries full of chattering and laughing modern "ladies of the lamp" bounded across our orchard, in their wake a host of male camp-followers in jeeps and on motor-bicycles, a reversal of ancient military tradition we had not anticipated. Their luggage train when dumped showed formidable stacks of tin trunks and other paraphernalia (memories of a return journey from Egypt when an attachment of twelve Sisters had between them 14 tons of luggage). There followed one or two hours of twitter in the camp before a number of the new arrivals departed in the vehicles of the camp-followers to dine out. The revellers returned at a late hour and drove in their jeeps through our bivouacs and I narrowly escaped traumatic amputation of both legs. As we laid awake we wondered whether Florence Nightingale would have approved. There was, however, no doubt about the fact that her spirit and the quality of her work were evident in the days to come. The conditions for nursing could scarcely have been harder and more full of irritations and difficulties. Over all these they rose supreme and did a grand job of work cheerfully and well. Generally there was no water to wash patients and little for them to drink. When we opened latrines were not ready. Primus stoves consistently misbehaved, illumination was by hurricane lamps. Many of the orderlies were raw and untried in nursing and in service conditions. We were about eight miles behind the lines and for some weeks we worked as a C.C.S., not holding our patients longer than 48 hours. We had to start operating with the tables placed at bizarre angles on the rough field surface, but in a few days concrete floors were laid in the two tented theatres and gave us stability so far as the position of the patient and our stance were concerned. We operated in mackintosh aprons. Gowns and gloves were reserved for work inside the body cavity and

joints. Washing was done in an enamel basin in which the water was changed about once in two hours. The efficiency of soap is shown by the fact that bacteriological tests on the water before use showed the presence of colonies of micro-organisms, whereas that which had been washed in about six or more times and was apparently dirty, proved to be sterile.

We worked all day and much of the night. The load of "full documentation," in spite of C.C.S. conditions, made our burden heavy indeed. We were told before the campaign that this time we would not be unduly tried by excessive documentation. A new form was devised, the A.F. I.1224, and the A.F. I.1220 was to be typed out from the former by the hospital office staff. Within a few days the office staff could not contend with the A.F. I.1220 and cast these upon us. Including the field medical card, we had therefore to write three copies of every note and a fourth when we wished to keep a record for ourselves. Apart from this were other forms dealing with S.I. and D.I. lists, accidents, self-inflicted wounds and so on. Such work necessitated long nocturnal sessions by the light of a hurricane lamp. It was wasteful of time and energy and in time sapped even the toughest.

Three days after opening we accommodated 1,100 patients, and fresh convoys arrived about every other day. Some nights will ever remain vivid in our memories. The sky fitfully lit with tracer, artillery fire, flares and exploding bombs, the bark of the guns, the patter of rain on the tents and the bobbing and swaying of hurricane lamps carried alongside the stretchers as the bearers squelched and slipped over the sodden ground with their load of soiled, bloody and mangled humanity to the resuscitation ("resurrection") tent and thence to the theatre. The smell of blood, mortification, gangrene and dirt stayed in one's senses for hours after leaving the theatre. Wounds alive with maggots and matted with filth of middens on which the soldiers had lain for several days, and uniforms loaded with lice will not be forgotten. The Germans stank considerably, and this was particularly so in the battle around Falaise, where they had been left out unattended for up to four days.

About this time we collected the contents of two Section Sanitat (German Field Hospitals). These had been shelled and retired to be shelled again, and then to escape this had advanced again. They were in an appalling state of professional demoralisation. Their vehicles contained unpacked anaesthetic apparatus and nursing utensils. Their wounded lay untended

on stretchers. Those who had the strength turned to urinate on the ground, others did so into their clothing. Doctors and orderlies stood about smoking cigarettes, except one surgeon who was amputating an arm without an anaesthetic. Their wounds were foul, being covered with thick greyish-green sloughs and dripping with pus. Those that had been operated on had thick rigid black rubber tubes stitched into the skin. One of my German patients who had been wounded over the sacral region was bristling with seven such tubes. Three developed tetanus, two of these survived. It seems that the German Army does not give tetanus prophylaxis. I understood from a German medical orderly that typhus inoculation is only given for good Nazis with four or more children. Several prisoners asked us for tetanus prophylaxis.

Some of the Germans, particularly the junior officers, were arrogant and most unpleasant, others were cowed and believed that they were going to be shot, although indeed there were no guards at all on some of their wards and the escape route was easy, as indeed some of the officers found.

Knowing the very low and dreary diet given to our prisoners in German hands, it was irritating to see the Germans given second helpings of our liberal hospital rations and to receive Grade I salmon and other luxuries.

The toughness of some of our countrymen is remarkable. One soldier, a west countryman, was hit by a shell fragment in the neck. He had a sucking wound over the apex of his lung and an oesophageal fistula. He was taken prisoner. In a German C.C.S. he arranged his escape with four Americans, murdered the German guard by stabbing him to death with his pocket knife, and roved with his companions behind the German lines for four days. Any food or drink he took came out of the wound in his neck. He and his colleagues persuaded about fifty Germans to surrender to the Canadians and so were rescued.

In the autumn torrential rain made living conditions under canvas rather damp and adhesive. In some places the mud was ankle deep and fluid, in others it was boggy. Our clothing was never dry, we had no stoves in our tents and it was not till nearly mid October that one was obtained for the mess. Despite the squalor, we were remarkably fit and only once was a rum ration considered necessary.

Normandy will be remembered for its rolling hills and woods, its orchards, substantial stone farms and its calvados, an alcoholic beverage of varying potency made from cider apples.

We discovered too late that the maturer forms of this local fire-water should be treated as a liqueur and not quaffed like vin ordinaire, as occurred on one memorable night when spirits were flagging and bodies fatigued. The toxic effect of this drink has an acute and critical onset. It struck at the apparently sober in a pole-axing manner. Respectable doctors were suddenly prostrated in the long grass, in ditches and hedgerows, a revered quartermaster lay in the Trendelenburg position festooned and blaspheming in the guide ropes of a marquee

tent. Some in attempting dental ablutions fell to the ground, never to rise again. A small band of survivors had to act as a rescue, recovery and search squad for the casualties, some of whom looked nigh unto death.

About the middle of October we closed the hospital, sat down in the mud and waited. I was posted to a hospital in Belgium. It was odd to tread a firm floor, to have laundry facilities and a bath again, but the heated air of the building made the nasal sinuses congested; and the feeling of rude health departed.

PLASTER OF PARIS BANDAGES IN SURGICAL CASES

The following paper has been prepared in the hope that it will provide a practical knowledge of plaster technique and at the same time eliminate some of the mistakes liable to be made by the novice. Upon the correct application of the plaster of Paris bandage depends, not only the successful maintenance of the surgeon's work, but the immediate comfort and ultimate rehabilitation of the patient.

The older metal or wood splinting has been gradually replaced by plaster, because the plaster, by conforming firmly to the contours of the limb, holds it in position more firmly and more comfortably. At the same time the application is easier and quicker, depending only on the setting time of the plaster, and the progress of the lesion can be followed by X-ray without disturbing the splint. Detachable splints may be made for occasional wear.

The material required for making the bandage is Plaster Muslin, sometimes known as Book Muslin, Gauze or Crinoline. This is used as a base for the plaster of Paris which is rubbed into the mesh. After careful experiment the mesh of the material has been standardised at about 30 threads to the square inch each way. Plaster of Paris (Calcium Sulphate) is a white powder derived from gypsum, dehydrated and pulverised. Immersion in warm water causes re-crystallization which makes the plaster set firmly. The amount of plaster in the bandage can be varied according to the surgeon's requirements. The setting time can be hastened by using hotter water or by the addition of a little salt or Potassium Sulphate, but an excess makes the plaster too friable and likely to crack. Alum in the water is used to make it harder. Other materials used in

plaster technique are Stockinette, Open Wove, and Domette Bandages, Gamgee tissue, Draper's wool, felts, flannel bandages and wooden poles which can be used as extra supports.

The making of the bandages requires practice to maintain a uniformity in size and a high and consistent percentage of plaster. The muslin should be cut in strips about six yards in length and four, six or eight inches in breadth. The strips are rubbed carefully into the powder at the bottom of a strong, oblong box, leaving the first six inches free to act as a sop to the water. Then the bandages are rolled loosely and stored in a damp-proof box. If the bandage is too tightly rolled water will not percolate through completely and if it is too loose the plaster will seep out. The length of time in store has a slight effect on the setting time.

When required the bandages should be immersed for two to three minutes until all the bubbles have ceased. Two bowls of water with three bandages in each gives the best result. The bandage is removed by holding both ends and pressing towards the centre to expel the water. One is then unrolled for a few inches before it is handed to the surgeon for application.

It has been found that soft water is unsuitable for plaster work and if it has to be used it should be hardened with a little chloride of lime.

Reinforcing back slabs can be made to any size and thickness by folding lengths of the bandage on top of one another. Alternatively a length of rubber tubing can be cut as required and used for the same purpose.

Plasters do not stretch or contract when

drying and so they should be wound lightly round the limb. It is important to rub the plaster continually into a solid mass in order to spread it evenly and to avoid opacities in the X-ray pictures.

During the application and the drying of the plaster the limb must be maintained in the correct position. Indentations can be avoided by resting it on a pillow as these are likely to give rise to pressure sores. A plaster which includes the knee should be put in about 50° of flexion.

Plaster casting may be required when it is necessary to provide a model for the construction of a surgical appliance. The limb is

smeared all over with vaseline and a thin metal strip is placed along it. Plaster is applied over this and when semi-set, a sharp knife is used to cut down onto the strip. The plaster is gently removed and a bandage wrapped around it to keep it in shape. The instrument maker can then block the end with paper and make an internal cast with paraffin wax.

The type of plaster to be applied and the extent of application is the surgeon's decision, but it is the responsibility of he who applies to calculate where the strain will fall and to strengthen the plaster proportionately.

A. W.

ON TWINS

By D. W. WINNICOTT

The first thing to say about twins is that they are a perfectly natural phenomenon and really nothing to be sentimental or facetious about. I know many mothers who have loved having twins and I know many twins who have liked being twins. But nearly all mothers say they would not have actually chosen twins had they been asked, and twins, even those who seem quite contented with their lot, usually tell me they would have preferred to come one at a time.

Twins have their own particular problems to solve. Whatever the advantages of being a twin, there are also disadvantages.

First I must remind you that there are two different sorts of twins, because the problem is not exactly the same for each kind. Sometimes after the first division of the newly-fertilized ovum each of the two cells divides and then develops independently, and this is the beginning of identical twins, two babies developing from the same fertilized ovum. Identical twins are always of the same sex, and they are usually very like each other in appearance, at least at first. The other kind of twins may or may not be of the same sex, as they are just like any other brothers and sisters, only they developed from ova that happened to be fertilized in the womb at the same moment.

Looking at twins of either kind we easily feel that it must be nice for each child to have company, to be never alone, especially as the two get older. There is a snag, however, and to understand this we have to remind ourselves of the way that infants develop. How does an infant first come to accept another?

In ordinary circumstances and with ordinary good management infants start immediately after birth to form the basis of their personalities and of their individuality, and to discover their own importance. We all like unselfishness and a willingness to allow for the other person's point of view and hope to find these virtues in our children, but if we study the emotional development of the infant we find that unselfishness only comes in a healthy and stable way if it is based on a primary experience of selfishness. It might be said that without this primary selfishness a child's unselfishness gets clogged up with resentment. Anyway, this primary selfishness is no more than the infant's experience of good mothering, a good mother being willing at first to fit in with her baby's desires as far as possible, letting the baby's impulses dominate the situation. A good mother is contented to wait for her baby's true concern for the other person's point of view to come in the course of time. At the start she must be able to give her baby the sense of possession, the feeling that he has control over her, till he becomes able to allow her her own private life. With the experience of primary selfishness in his bones he will be able to become unselfish without too much resentment.

Now in the ordinary way, when babies come in ones, each little human being can take his own time to recognise the right of his mother to other objects of concern, and it is well known that another baby is not welcomed by a child at first—not in fact for many months. No mother would worry if her baby failed to appreciate the benefits of the companionship of

other babies till well after the first birthday, and even two-years-olds may bash each other rather than play together at first if they are put together. The fact is that each baby has his own time for welcoming a brother or sister. It is an important moment when a little child can genuinely "give" (that is allow) his mother a new pregnancy.

Now the twin has another baby thrust on him quite apart from his ability or willingness to allow his mother to add to the family. This is one of those places where those who hold the view that little things do not matter in the early months come unstuck, because it matters very much whether twins do or do not feel that they each had possession of mother at the start. The twin's mother always had another baby. The mother of twins has an extra task on top of everything else, which is to give the whole of herself to two babies at once, and to some extent she must fail, since it really is impossible to treat two babies exactly alike. The mother of twins must be content to do her best and hope that the children will eventually find advantages that will compensate for this inherent disadvantage of the twin state.

It is impossible for one mother to treat two infants alike because, for instance, she cannot take up each of two children first, whether to feed them, or to change their napkins, or to bath them. She can try very hard to be fair, and it will repay her if she takes this matter seriously from the beginning, but it cannot be easy.

As a matter of fact she will find her aim is not to treat each child alike but to treat each child as if that one were the only one. That is to say, she will be trying to find the *differences* between each from the moment of birth. She of all people must know each from the other easily, even if she has to tell one by a little mark on the skin or by some other trick. She will usually come to find that the two temperaments are different, and that if she easily acts in relation to each as a total personality each will develop personal characteristics. It is thought that a lot of the difficulty about twins arises out of the fact that twins are not always recognised as different from each other even where they are different, either because of the fun of it or because there is no one around and about who thinks this task worth the trouble. I know of a quite good home in which the matron never learned to distinguish between two twin girls, although the other children had no difficulty in knowing one from the other because the two girls really had quite distinct person-

alities. The matron used to call each one "Twin." This seems to me to be awful.

And it is no good for the mother to try to solve the problem by looking after one herself and handing the other over to a nurse; she might have to do that for some good reason, if she is very run down, for instance; but by that method she will do no more than postpone things, because one day the twin she parked out is going to be very jealous of the one she kept, even if the parked-out twin had good mothering from someone else.

Mothers of twins seem to agree that even when the twins like being alike and being mistaken for each other, these same children need their own mother to recognise the identity of each without trouble. It is essential in every case that there should be no confusion among the children themselves, and for that there must be some person in their lives who is quite clear about them. A mother I know had identical twins, exactly alike to outsiders, but they were distinguished by their mother from the beginning, because of their temperaments. In the first week or so this mother complicated her feeding routine by wearing a red shawl. One twin reacted to this and simply gazed at the shawl, perhaps at its bright colour, and lost interest in the breast. The other, however, was unaffected by the shawl, and fed as usual. After this the mother felt not only that the two were two persons but also that they had already ceased living parallel experiences. This particular mother got round the who-to-feed-first? difficulty by having the feeds ready well on time and feeding first the infant that seemed more eager. It was usually easy to decide by the crying. I do not say this method would suit all cases.

Certainly the main complication in the upbringing of twins is this question of the personal treatment and management of each, so that the wholeness and oneness of each gets full recognition. Even if there were twins that were exactly alike there would still be need for their own mother to have a whole relation to each.

One good idea is to put one baby to sleep in the front garden and the other in the back. Of course, there may not be two gardens, but it may be possible to arrange things somehow so that when one infant cries there will not always have to be two crying. Not only is it a pity from the parents' point of view to have the two at it at once, but also when a baby cries he likes to dominate the scene; it's maddening for him to have a rival in early infancy

at the stage of natural dictatorship, and I have known the effects of this sort of thing persist long into a twin's life.

Twins of one kind are called identical twins. Surely this word gives the whole show away. If the children were identical they would each be the same, they would add up to one, so to speak, which is silly. They are similar but not identical, but the danger is that people insist on treating them as identical, and if people do this, the twins will feel *themselves* muddled about their *own* identities. And infants do become very muddled about their own identities apart from being twins; it is only gradually that they become sure of themselves. As you know, it is quite a while after words are used that children use pronouns. They say, "mum" and "dad" and "more" and "dog" long before they say "I" and "you" and "we." It is more than possible for twins to sit in a pram, each thinking the other is not a separate person. Indeed, it would be more natural for an infant to think he sees himself at the other end of the pram (rather like looking in a mirror) than to say in infant language "hullo, there's my twin opposite me." But when one of the two gets lifted out of the pram the other feels infinitely lost and let down. Here is a

difficulty that any baby may have, but that twins must have, and they can only hope to manage if people play their part and know them as two people. If the twins do themselves eventually become quite confident about their identities they may enjoy exploiting their likeness to each other, and then, and not before then, is the time for fun and games on the theme of mistaken identity.

Finally, do twins like each other? This is a question that twins must answer. From what I am told I feel that the idea that twins are specially fond of each other needs looking into. Often they accept each other's company and enjoy playing together and object to being separated, and yet fail to convince one that they love each other. Then one day they discover that they hate each other like poison, and at last the possibility that they may get to love each other has come. After the hate is expressed the love has a chance. So it need not be taken too much for granted that twins want to spend their lives together. They may, but they may not, and they may even be grateful to some chance thing like measles for separating them, it being much easier to become a whole person alone than in the company of one's twin.

MY LADY AND MY LADY PHILOSOPHY

(With deference to Dante)

Last night we lay
And loved the line of limb
That leads to life's (and love's) display:
The nuptial line of lap and limb that lends
Its likeness to the cold and warm
Compress of lips, that spends
Its passion.

So was this passion spent.
As treasure, loved and lost, it went.
And yet no void remained, no ache, no lack
Of what had gone, no vacuous space of pain;
It was her eyes that turned the passion back,
Both clapped it off and caused its stage again.
It was the corneal clarity,
The utter sparkling charity
With nothing in disparity,

Though born in nice obscurity;
Its end its own annuity;
The floating pupil purity,
The single depth beyond.
And thus the thrill of old, returned, refined.
I saw it first aslant, my eyes on her's,
Set deeply in the singleness of mind,
Which she alone, my second love, confers
With intellectual clarity intent
Upon the sparkling sport of argument.
I find without surprise
I've plighted twice my troth,
And through my lady's eyes
Last night I met them both.

NAT.

Contributions for the December issue of the JOURNAL should reach this office by November 15th.

BITS AND PIECES

Glancing through my London University guide book for the 3rd M.B. examination, I came across Section 2 of Part 1.

"(2) Hygiene and forensic medicine

(a) One paper of three hours duration.

(b) An oral examination in Hygiene. (*Public Health and State Medicine*)."

This reminded me of the lack of attention given to these subjects in the college curriculum. No doubt this is due in part to lack of time during the shortened wartime course. All the same it seems a little incongruous that when the country is clamouring for more food, more babies, better housing; when we are threatened with epidemics, declining populations, inadequate hospital accommodation, that the average qualifying student should have so little knowledge of Social Medicine.

The annoying little section I have noted above is regarded in the best circles as just one of those damned things one is asked in the finals. There is no desire to approach the subject fully since there is little understanding of the need for the social approach to medicine.

A forecast of the population of 1995 shows a considerable decrease, mainly due to a decline in the birth rate.

The writer knows of an anatomist who is not at all surprised at this and to whom the event

of parturition is so remote a possibility in a woman's life that it's a wonder there is a human race at all. But then there is you know, and the Maternity department can vouch for it that a baby is born once in a while.

Why though this decline in birth rate? Well, some people who ought to know say it is due to the average parents' fear of social insecurity. This means among other things not knowing whether the family income will amount to enough to house, feed and clothe it and whether war will remove the breadwinners, destroy life, property, kith and kin.

There is a rumour going round that the country needs more doctors. The writer suggests that many suitable individuals would be able to set out on a course of medical studies if more financial help were available to enable them to live during the expensive years of undergraduate life.

At the present time it is estimated that the minimum cost of board and lodging in London is £2 10s. per week and in the provinces somewhat less. State bursaries were granted in various sciences considered vital to the war effort. The nation's health is of vital importance in peace or war.

Then how about State Bursaries in Medicine!

ONLOOKER.

ANNOUNCEMENTS

THE ROYAL COLLEGE OF PHYSICIANS

Dr. C. M. Hinds Howel is now the Senior Censor and Dr. George Graham the Second Censor of the Royal College of Physicians.

THE JOURNAL

Mr. Peter Banks has resigned the editorship of the JOURNAL. The Publication Committee accepted his resignation with great regret. He will be succeeded by Mr. Hugh Cornford, formerly Assistant Editor.

CORRESPONDENCE

THE MARRIED
EX-SERVICEMAN

To the Editor, St. Bartholomew's Hospital Journal
Sir,

In these days when the younger amongst us in the Services realise that a period of many months must elapse before our astronomical "demob." numbers turn up, we have to satisfy our longing for home with vague conjectures as to the future. Some definite statement of policy from the "mother hospital" would, therefore, be very welcome as it would give us some idea as to what is being planned for our further medical education and welfare.

What scheme has the Hospital for allotting

"House Jobs" for ex-Service personnel, and how will those of us who went straight in after six months "on the House" stand in competition with the more fortunate ones who did B2 and/or B1 jobs?

One of the London teaching hospitals has made arrangements for married ex-Service housemen to be accommodated in an adjacent block of flats. Could anything similar be found in Charterhouse Flats or Chambers?

Yours faithfully,

J. R. COOPER, Capt., R.A.M.C.

No. 3 British Base Transfusion Unit,
Poona,
India Command.

October 3rd, 1945.

THE ABERNETHIAN SOCIETY

At a meeting of the Society on September 28th, Col. Hugh Leavell, of the United States Public Health Service and UNRRA, addressed members on the subject of "Public Health Services in the United States." In this talk conditions in the United States were contrasted with those of our own country; in particular the speaker referred to the gross variation in population in different parts of the vast country, the colour problem, the climate, and to diseases such as amoebic dysentery and malaria which are endemic in certain states. It appeared that the American public showed a greater disease-consciousness than our own, as evidenced by the widespread appeal of charity supported "foundations" for the relief of poliomyelitis and tuberculosis and by the almost universal insistence on pasteurised milk from tuberculin-tested herds. When Col. Leavell dealt with

the actual organisation of health services it came as a surprise to learn of its close similarity to our own. Although a system of Health Centres was by now well established in many states, it served for the most part a solely administrative and educational function. Many of the deficiencies of our own health services are no nearer to solution upon the other side of the Atlantic, and it was a comforting thought that even in the country of the otorhinolaryngologist, the autopsy surgeon and the esophagus, patients sometimes wait for three hours in an out-patient department reminiscent of the booking hall of a railway terminus for their ration of *Haustus Gentianae cum Rheo Alkalinus*.

The November meetings of the Society are a Clinical Evening to be held on November 8th.

SPORTS

SWIMMING

The Swimming Club is being reformed in London. They have already won their first match. A full account of this and subsequent matches will appear in the December Journal.

SOCCER

Bart's v. St. Mary's Hospital. Home. Won 4-2.

In a fast moving game, Bart's began pressing early, and our forwards were moving the ball well against a heavier defence. Burns was unlucky to have a good shot fisted out before Bart's opened the scoring, through Thomas, who headed in a good centre from Burns. Pilling then scored from close in, and Morgan again increased our score shortly afterwards by sending in a good header, this time from a centre by Blackman.

In the second half Mary's played better, and

quickly scored. However, Mangan sent across a low centre from the left wing, and Thomas put in a first-time shot which gave the goalie no chance. Mary's continued to play hard and scored again just before time.

Our forwards played well, but would be better if they played more together. The defence was rather unconditional, and indeed the two goals scored against us could have been prevented. However, the game was an encouraging start to the season.

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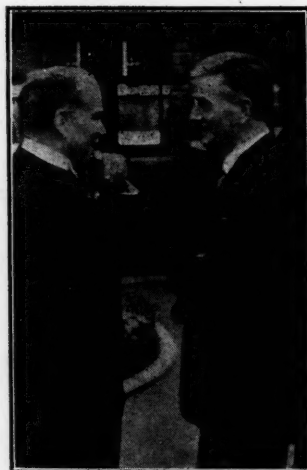
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